COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

Not One More Death From Child Abuse and Neglect:
A 21st Century Strategy for Protecting Our Kids

CECANF FINAL REPORT: Proposed Outline

Letter from the Chairman: This may contain a high-level executive summary, "headline" recommendation, or preview of themes and recommendations.

Story of one community taking a promising approach to addressing child abuse and neglect fatalities: Options include Pima-Maricopa, Wichita, Hillsborough County, and El Paso County.

- **Introduction:** States the problem, its impact (including the economic and social costs of child fatalities), and the promise of a solution (including smaller-scale approaches that have focused on taking collective responsibility, mobilizing leadership and accountability, and improving measurement and classification).
    - A national tragedy: Overview of the scope of the problem, including near fatalities
    - Economic and social costs of child fatalities
    - Familiar cycle: 1. Tragedy occurs, 2. Gets lots of press attention, 3. Politicians take notice, 4. CPS agencies get rebooted, 5. Same cycle starts up again.
      How can we break this cycle of failure?
    - Time for action: CECANF's charge & process
    - Lessons from the past (Building on success: how other safety problems have been solved)
    - The Commission's solution: A strategy for the 21st century (overview)

- **Chapter 1: Why We Need a Strategy for the 21st Century**
    - Intro: The primary government agency responsible for protecting children from child abuse and neglect is county- or state-run child protective services (CPS). A narrow focus on the CPS agency alone has not proven to be enough to eliminate child abuse and neglect fatalities.
    - Key points:
        - A community's child safety system involves many organizations and individuals beyond CPS.
        - Comprehensive, overarching strategies to eliminate fatalities are lacking at the state and federal levels.
        - The CPS agency does not always see children before they die—in part due to the young age of the most vulnerable children.
            - When CPS does see children at risk, the agency's ability to intervene to prevent serious injury or death is limited by a number of factors:
                - Policy (reactive vs. proactive system)
                - Funding/workforce/resource issues

- Lack of evidence-based approaches
- Access to/control of effective services

SECTION I: CORE COMPONENTS OF THE NATIONAL STRATEGY

- **Chapter 2: Collective Responsibility for Safety**

  [*Proposed story: Wichita, KS – collective impact model*]

  - Intro: Collective responsibility for child safety is at the core of our 21st century strategy for protecting children. This collective approach requires a safety-focused ecosystem in which child protective services, health care, public health, education, early childhood, law enforcement, families, and other partners work together toward the common goal of preventing child abuse and neglect fatalities. These efforts must be proactive, comprehensive, and prioritize the children most at risk.
  - Key points:
    - Ensuring collective responsibility for child safety requires a paradigm shift.
    - This effort must encompass a continuum of supports to ensure child safety, from proactive upstream prevention to child protective intervention services for families in crisis.
    - There are numerous potential touchpoints for prevention before a fatality occurs. A web of formal and informal systems (beyond child welfare) touches children and families and must be engaged in the prevention of child maltreatment fatalities. Some of these touchpoints include health care, WIC programs, early childhood providers, law enforcement, and more.
    - Data on child maltreatment fatality risk and caregiver mental health status, substance use, etc., highlights families most at risk and in need of proactive supports.
    - We have an opportunity for greater impact by aligning our prevention efforts with broader systems transformations under way, particularly health care reform and health system redesign.
    - Understanding local needs and neighborhood context is critical. (E.g., Initiatives in Sacramento and Wichita are both locally driven and based on a collective impact model. They both used geographic mapping and a needs assessment to focus on communities of high risk.)
  - Recommendations:
    1. States should be required to develop and implement a comprehensive state plan to prevent child maltreatment fatalities. These state prevention plans should take a public health approach, with CPS being one of multiple key partners.
    2. Create national and sustained leadership and incentives to move state/local/tribal agencies (in addition to CPS) to prioritize prevention of child abuse and neglect fatalities as a critical part of their mission.
    3. Enable more flexible funding and place-based strategies to better integrate and align cross-system efforts.
    4. Enhance dual-generation funding strategies to support families and help to break the intergenerational cycle of abuse.

- **Chapter 3: Leadership and Accountability**

  [*Proposed story: Salt River*]

  - Intro: Leadership at every level is necessary to create a sense of urgency, sustain attention, drive a collective approach, and shelter this effort from competing priorities (include examples of where accountability is currently lacking).
  - Key points:
    - A collective strategy (as described in the prior chapter) must be coordinated and have clear lines of responsibility to avoid a situation in which everyone is responsible, but no one is accountable.
    - Accountability or performance management has many components, including enforcement and oversight of federal and state child welfare policy, collective responsibility and accountability, transparency, and accountability for outcomes.
    - There should be an unambiguous national priority of child safety and eliminating child abuse and neglect fatalities. Leadership is a critical component for implementing complex system changes for eliminating child abuse and neglect fatalities.
  - Recommendations:
    5. The issue of Child Abuse and Neglect (CAN) fatalities should be declared a public health issue by the U.S. Surgeon General and be one of the key priorities of the Surgeon General's National Prevention Strategy within the priority of Injury and Violence Free Living. (The Strategy was established to identify the most effective and achievable means for improving health and well-being and prioritizes prevention by integrating recommendations and actions across multiple settings to improve health and save lives.)
    6. The Federal Interagency Work Group on Child Abuse and Neglect needs to be restructured, refocused, and funded to ensure there is dedicated federal leadership on the issue of CANF among several government agencies (including HHS, DOD, DOE, CDC, NIH, DOJ, IHS, BIA, and more) to further Commission recommendations, study the impact of recommendations over time, make additional recommendations and provide the leadership necessary to engage a diverse array of stakeholders from state and local policymakers, to business leaders, to individuals to champion programs and policies to eliminate child abuse and neglect fatalities.
    7. The Children's Bureau should re-examine its oversight and management of state title IV-B Child and Family Service Plans to ensure that they align with federal goals, promote efficiency, and serve as better oversight tools.
    8. Congress and the administrative agencies should re-examine existing policies (CAPTA plan of safe care, ASFA reunification bypass) and address documented gaps and lack of clarity to drive high-quality implementation in the field.
    9. The Child and Family Services Reviews should do more to serve as an accountability tool regarding child maltreatment fatalities.

10. Use the Government Performance and Results Act to set federal goals and targets on child safety, with emphasis on preventing child abuse and neglect fatalities across federal agencies.
11. The federal government should have a full range of authority needed to ensure state compliance with federal policy and law, up to and including legal action.
12. HHS should provide examples of best practices in state-level policies such as safe haven laws.
13. HHS agencies, namely the Children's Bureau but also the Center for Medicaid and CHIP Services, Office of Child Care, and others, should provide clear and timely guidance and tools to assist state and local child-serving agencies in achieving safety goals.
14. States should be required to develop and implement a comprehensive state plan to prevent child maltreatment fatalities. These plans should take a cross-system preventive approach, with CPS as one of multiple key partners. Health and public health must be at the table.
15. CPS agencies should have quality assurance plans for the timely review of practices critical to maintaining child safety and the ability to provide immediate feedback and make adjustments as necessary.

- **Chapter 4: Measurement and Classification**

  [*Proposed story: Hillsborough County*]

  - Intro: The ability to accurately count the number of children who die from CAN is critical in order for us to know whether interventions designed to decrease fatalities are working and whether the resources being provided to address this problem are adequate based on the magnitude of the problem.
  - Key points:
    - Child maltreatment deaths are not all the same.
    - The current way that child abuse and neglect fatalities are counted—both in terms of overall number and classification of deaths—is not accurate.
    - Accurate measurement requires changes in investigation and classification of deaths.
  - Recommendations:
    16. Develop a surveillance system based on a public health model that builds upon existing related federally funded systems (e.g. child death case report, national violent death reporting, uniform crime reports, sudden unexplained infant death registry). This recommendation was echoed by virtually every expert who spoke to the Commission who is not under the auspices of a single agency responsible for investigating CAN fatalities.
    17. Develop a consensus about what do we have to count. Improve the understanding and counting of child maltreatment fatalities and near fatalities by rapidly developing a standardized classification system. Develop, field-test and implement uniform operationalized definitions for child maltreatment to establish reliability. These

definitions should be public health-focused operational definitions. They should not rely on an agency-specific determination of maltreatment. They should not necessarily be for use in the child welfare system or in criminal determinations, but rather for the specific purpose of counting child abuse fatalities so that we can understand the scope of the problem and develop and evaluate prevention efforts. These definitions need to be operational and need to include levels of uncertainty (e.g., presumptive, probable, and possible maltreatment). There needs to be specific and on-going training and guidance to all professionals who are making decisions about classification of fatal CAN and determining how to get teams to use the definitions consistently.

18. Promote multidisciplinary investigation of certain child fatalities (e.g., unexpected, sudden, suspected CAN) and improve the qualifications and training of investigators. Improve and standardize (through training and practice) the quality of death scene investigation, the determination of death. Improve the identification of fatal CAN from vital records/death certificates by adding a check box to indicate child maltreatment, similar to the check boxes currently in use to identify other significant conditions or exposures of public health interest, such as work-related injuries and tobacco-related. Develop standards for investigation and resourcing of expertise in investigation and certification.
19. Develop a typology of fatalities, each with its own risk factors, intervention strategies, outcomes, etc., and delineate societal from family from individual characteristics for each type of fatality. Identification of successful interventions for specific types of fatalities, identification of necessary policy changes, and determination of culpability as appropriate.
20. Congress should make submission of data to NCANDS mandatory. ACF should expand data collected by NCANDS to include more specific information about children who die from abuse or neglect whose families have history with the CPS agency. Build a public health child maltreatment fatalities registry and expand/standardize reporting of fatalities into NCANDS. Mandate that states report child abuse and neglect fatalities to NCANDS through the state's health or public health agency utilizing a medical examiner to make the final determination.

SECTION II: APPLYING WHAT WE KNOW

When the three core components come together, communities can more effectively apply what we know to save lives.

- **Chapter 5: Implementing Stronger Child Protection Methods**
    - Intro: We must apply what we know *now* to save children's lives, through a collective commitment to more effective identification, assessment, and treatment of children and families at risk. This section lays out how we can strengthen our assurance of child safety through efforts by CPS agencies and other key partners (e.g., law enforcement, domestic violence services, substance abuse, mental health, health care, public health, education, and others).
    - Key points:
        - We know some of the families who are most at risk. For example, we know that young mothers with significant mental health needs are at higher risk of fatal maltreatment.
        - With as many as 50 percent or more of child abuse and neglect fatalities involving children never known to the CPS agency, earlier recognition and support to caregivers presenting with fatality risk characteristics is essential.
        - There are promising findings from integrated care delivery systems models (e.g., Montefiore's integrated adult and pediatric care).
        - We are starting to build an evidence base around what works. For example, there is growing data around the effectiveness of home visiting programs, particularly for prevention of supervision neglect-related fatalities.
        - With as many as 50 percent or more of child abuse and neglect fatalities involving children whose families were previously known to the CPS agency, it is critical that CPS agency safety assessment and corresponding intervention strategies be supported by stronger science and multidisciplinary expertise.
        - Almost 74 percent of all child maltreatment fatalities involve children under the age of 3. There is a need for a multidisciplinary response and review of CPS referrals for this age group.
        - CPS agencies have evolved to triage and prioritize responses to children based on present danger. Evidence suggests that the vast majority of CANF fatalities involving children or families with prior CPS agency contact occur in families initially judged to be less serious owing to the apparent absence of present danger. CPs agencies must become more attuned to impending and emerging danger as well.

            - Because it is difficult (or impossible?) to identify which specific children—among thousands identified to be at risk—will ultimately die from child abuse and neglect, it is important to support at-risk families by applying effective prevention strategies long before these families reach a crisis.

- Recommendations:

  Upstream Services:

  - Expand home visiting:

    21. Test and develop the ability of home visiting to reduce child abuse and neglect fatalities. Utilize the research infrastructure through the national Home Visiting Research Network to support this effort.
    22. Ensure every family involved with CPS gets expedited access to home visiting services if it is an appropriate intervention.
    23. Expand Medicaid coverage for home visiting services.

  - Enhance screening:

    24. Expand the screening of caregivers for elevated risk factors (e.g., Oregon's well-being screen or Montefiore's ACES screen) and provide upstream connections to services.
    25. Ensure that health information exchanges facilitate access to injury and health service histories of children at the point of care.
    26. Develop evidence-based screening tools for ACEs.
    27. Support postpartum depression screening for the prevention of child maltreatment.

  - Investigate more supportive payment strategies:

    28. Identify new payment strategies that might reimburse family-based services (e.g. parental mental health services) in meeting the responsibilities of EPSDT for a child.
    29. Capitalize on state and payer investment in primary care medical homes and health homes to increase access to trauma-informed programs (for both parents and children), home visiting services, and other family-based social services within primary care settings.
    30. Expand efforts to shift reimbursement to both think about the "whole family as a system of health" and then the "health care delivery team as a whole system."

  - Address family stress:

    31. Develop policies that address sources of stress in parents and give adults tools and training for dealing with toxic stress to help diffuse potential child maltreatment before it happens. Integrate strategies that build child and adult capacities to succeed within complementary policies that collectively lower the burden of stress on families.
    32. Target families that enter into the child welfare system with supports and training designed to reduce major stressors in their lives and build healthy relationships.

  - Expand access and improve pediatric services:

    33. Ensure that all children eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit within Medicaid are receiving the necessary pediatric services.
    34. Develop new pediatric quality measures for family risk assessment, failure to thrive, and early childhood injuries.

35. Develop clinical guidelines for specific injury situations (e.g., infant with a bruise and a fracture, child with a burn) in order to decrease missed cases of abuse in which the child goes on to have more severe injuries.
36. Fund and support child abuse pediatrics workforce development, and recommend to Congress the provision of federal training grants to support child abuse pediatrics fellowships and Graduate Medical Education loan repayments as incentives to expand the workforce and the number of trained researchers.

CPS Services:

- Enhance screening:
  37. Prohibit states from screening out reports made by mandatory reporters.
  38. Prohibit states from screening out reports for children under age 3 or with disabilities when reports are made by mandatory reporters.
- Improve safety assessment:
  39. Apply stronger research methods to the development of safety assessment criteria and adapt safety assessment methods to the changing context of CPS agency involvement over the life of the case.
  40. Develop standardized ways to measure severity of harm, severity of risk, and severity of maltreatment to an individual child and to the family/other children in the home. Develop tools to support decision-making at all touch points of the CPS system.
  41. Consider threat of harm as a basis for CPS agency response even when exposure to the threat may not yet have resulted in an incident of maltreatment.
  42. Expand the use of safety assessment protocols by law enforcement.
  43. Develop and implement secondary review protocols for children judged not to be in present danger to better recognize families in which threats of harm that may be present or protective capacities that may be weak. These conditions may not be presently endangering the child but constitute a high probability that serious harm will occur sometime absent an effective intervention.
- Multidisciplinary investigation and review:
  44. Congress should authorize funding to support a multidisciplinary initial CPS response to child abuse and neglect reports. Investigations should be conducted by multidisciplinary teams, to include clinical specialists and first responders.
  45. Congress should authorize demonstration projects involving multidisciplinary review of cases in which serious harm or endangerment has occurred.
- Prioritize services for children ages 0–3:
  46. All intake screen outs of referrals involving children ages 0-3 should receive a supervisory review. [Alternatively, agencies should consider a multidisciplinary team review of such referrals within a brief time following the screen out decision.]
  47. Investigations and assessments involving children ages 0-3 should include a multidisciplinary staffing.

48. Expand birth match.

49. Implement electronic cross reporting with law enforcement similar to the ESCARS in Los Angeles.
50. Implement real-time case reviews of high risk in-home cases with a specific focus on aspects of case practice that can increase the risk of a fatality such as Rapid Safety Feedback in Florida.
51. The Administration for Children and Families (ACF) and states should work together to identify standards for case supervisory and management oversight of practices critical to child safety.
52. Caseloads and workload should be designed to support the level of contact with families necessary to assess the current status of a child's safety and a caregiver's progress, with intensive contacts involved in instances in which children remain at home or have been reunified.
53. Ensure immediate access to effective mission-critical services, especially as they relate to adult mental health, substance abuse, insufficient caregiver protective capacities and domestic and interpersonal violence.
54. Prioritize prevention and support services to prevent and address abuse and neglect by young parents who are in the child welfare and juvenile justice systems (who have many of the risk factors, and whom we have responsibility for and full access to).
55. Expand the practice of baby courts.

- **Chapter 6: Developing New Tools and Strategies to Apply What We Know**
    - Intro: We must continually expand the cutting edge of our capacity to analyze data and employ resources based on the findings to protect vulnerable children.
    - Key points:
        - We know some things about the children and families most at risk for a child abuse and neglect fatality, but there is still a lot we don't know or cannot easily apply due to limitations in data systems, [other limitations to be addressed in this chapter].
        - Much can be learned from the safety culture and systems employed in other safety-critical industries such as aviation, health care, and others.
        - These lessons can be applied in child welfare (TN example, others) to prevent deaths from child abuse and neglect.
    - Recommendations:
        56. Eliminate barriers to collaboration and sharing of information across agencies that would allow effective safety investigations.
        57. Policies should be in place to facilitate and require data sharing among CPS, law enforcement, health care, and other relevant social service agencies to ensure the efficient assessment of risks and the delivery of services to children and families.
        58. Base confidentiality restrictions regarding sharing of information on what is needed to ensure child safety once children are referred to CPS.
        59. Create more efficient mechanisms to share information between jurisdictions, as families are mobile and sometimes move as a strategy to avoid CPS supervision.

60. Cross-reporting of all allegations of child abuse should be mandatory between law enforcement and CPS. Joint investigations should follow protocols established jointly by CPS, police, and prosecutors. Further, jurisdictions should adopt and implement Electronic Suspected Child Abuse Reporting Systems (ESCARS) such as the one developed in Los Angeles County that provides immediate notification to law enforcement for all abuse allegations.
61. Link multiple data sources in a way that is standardized, available for research (and ultimately practice), and continual (not a single linkage at one point in time with no ability to update).
62. Congress should create a capacity within ACF to regularly evaluate the strength of research evidence on near fatalities and fatalities and translate this research into implications for practice.
63. Congress should authorize and appropriate funds to support research on the criteria associated with serious harm or death from child maltreatment and on the effectiveness of current CPS safety assessments and safety planning procedures.
64. Resources need to be invested in research and development of effective interventions for families engaged with CPS who match a high-risk profile for a fatality.
65. Evaluate new approaches to looking at prediction and prevention of fatalities and near fatalities within communities—GIS/Risk Terrain Modeling, for example.
66. Require state CPS agencies to have Proactive Safety Management programs, also known as Safety Management Systems, similar to those required in aviation and hospitals.
67. Support states in the development and implementation of systemically oriented case review, such as is being used in the United Kingdom (Munro) and in Tennessee for all cases in which the child or family was known to the CPS agency.
68. Work with the pioneers of safety science to facilitate adaptation and incorporate lessons into child protection agencies.

- **Chapter 7: Considerations for Specific Communities**
    - Preventing Child Maltreatment Fatalities in American Indian/Alaska Native Communities
    - Addressing Disproportionality
    - Military
    - Other

SECTION III: NEXT STEPS

- **Chapter 8: Implementation/Next Steps**

SECTION IV: APPENDICES

- Protect Our Kids Act (text of the law)
- Commissioner names, photos, and bios
- List of meetings and people who have presented
- List of stakeholder events (est. 4 pages)
- List of stakeholder groups that we've engaged (est. 2 page)